



PATIENT HISTORY

In order to provide you the best care, it is beneficial to know as much about your health history as possible. Please complete this form to the best of your knowledge. Thank you.

Patient's Name: _____ DOB: _____ Age: _____ Date: _____

Occupation: _____ Currently Working? _____ Yes _____ No

Best Contact Phone Number: _____ Email Address: _____

Physician: _____

Past Medical History CHECK ALL THAT APPLY

- | | | |
|---------------------------|-------------------------|---------------------------|
| Allergies__ | Emphysema__ | Osteoporosis__ |
| Anemia__ | Heart Disease__ | Pneumonia__ |
| Angina or Chest Pain__ | Hepatitis/Jaundice__ | Polio__ |
| Arthritis/Gout__ | Hypo / Hyper glycemia__ | Rheumatic/Scarlet Fever__ |
| Asthma/Hay Fever__ | High Blood Pressure__ | Rheumatoid Arthritis__ |
| Cancer__ type_____ | High Cholesterol__ | Stroke__ |
| Chronic Bronchitis__ | Kidney Disease/Stones__ | Shortness of Breath__ |
| Cirrhosis/Liver Disease__ | Latex Allergies__ | Reflux/GERD__ |
| Depression__ | Migraine Headaches__ | Ulcers/Stomach Problems__ |
| Diabetes__ | Osteopenia__ | Urinary Tract Infection__ |

Other _____

Please list any prescription or over the counter medication you are taking?

Please list any x-rays, or other imaging studies you have had related to this condition.

PLEASE CONTINUE ON REVERSE SIDE



**Reynolds & Associates
Physical Therapy, Inc.**

Please list any operations that you have had and the date(s) of surgery:

Surgery	Date
_____	_____
_____	_____
_____	_____
_____	_____

Have you noticed any lumps/thickening of skin/muscle anywhere on your body? Yes No

Have you had any unexplained weight loss in the last month? Yes No

Do you exercise regularly? Yes No

Do you have any difficulty sleeping? Yes No

Do you have difficulty swallowing? Yes No

Do you experience episodes of dizziness? Yes No

Have you had 2 or more falls within the past 12 months? Yes No

Have you had any fall resulting in injury within the past 12 months? Yes No